Request for Anti-Tuberculosis Medications Additional Medications Form

Ship To:
Name:
Address:

Contact Person:

Kansas TB Control and Prevention Program

PLEASE PRINT CLEARLY

Patient HAWK # or Name	**DOB**	**Medication**	**Dosage**	**Quantity**	**Lot #**	**Prescription #**	**Comment**	KDHE Use Only

MEDICATIONS WILL BE LIMITED TO ATS/CDC RECOMMENDED TREATMENT REGIMES

Submit order by any of the following means:

mail: KDHE TB Control Program, 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274 fax: 785-291-3732

4/15/2005